COMOX STRATHCONA
REGIONAL HOSPITAL DISTRICT

Director Expense Claim Form

Name:		Address:			Date:	

Mo	Day	PURPOSE OF TRAVEL DESCRIPTION AND LOCATION	Time Departed Home	Time Returned Home	MEALS			OTHER	Description	ACCOMO-DATION	TOTAL
					BREAKFAST	LUNCH	DINNER				

I hereby certifiy that the expenses and expenditures detailed on this claim qualify for reimbursement and were incurred by me as a result of Comox Strathcona Regional Hospital District business as detailed in the CSRHD Bylaw No. 244, and any subsequent amendments, and that I will not be reimbursed for them by any other party.

Director's Signature		Date	

Carry Forward of KM expenses from reverse of form	**$**
NET CLAIM	**$**

PURSUANT TO CVRD REMUNERATION BYLAW #73	Reimbursement
1. Commercial Accommodation	Actual Cost
2. Non-Commercial Accommodation	$35/night
3. Overnight travel per diem (24 hour period)	$75/24 hrs
(Deduct meal allowance for meals provided and consumed at overnight event)	
4. Meal Allowances (must be away from home for the entire time period)	
Breakfast between 6:00am - 9:00am	$15
Lunch between 11:30am - 1:30pm	$20
Dinner between 4:30pm - 7:30pm	$25
5. All other expenses (with receipts)	Actual Cost

Verified by: _____

Account #	50-2-0-320 cc1 _____

COMOX STRATHCONA
REGIONAL HOSPITAL DISTRICT

KILOMETRE ALLOWANCE FOR AUTOMOBILE DISTANCE TRAVELLED

According to Schedule "B", CSRHD Bylaw No. 244 (consolidated)

DATE	LOCATION	PURPOSE OF TRAVEL	Distance on Paved	Distance on Unpaved

	TOTAL DISTANCE TRAVELED in KM		
	RATE PER KM	**$0.70/ KM**	**$0.84 / KM**
Carry forward to front of form	**TOTAL DISTANCE EXPENSE**	**$**	**$**